PREGNANCY COMPLICATED BY A DEGENERATING FIBROID

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THE main interest in this case lies in the difficulty the patient presented in arriving at a correct diagnosis and also the question of treatment.

MRS. B., AGED 28½, MARRIED 7/12 YEAR.

22/10/37.—The patient was seen first on this date on account of a *continuous uterine hæmorrhage,* which had lasted from 1/10/37. The previous menstrual period had commenced on 29/8/37, and was three days early.

The patient stated that the loss of which she complained had started at a normal menstrual period, but on closer questioning it was found that this period was really four days late. She was feeling nauseated, and had definite breast changes.

On examination.—A soft swelling was palpable just above the symphisis pubis. This was symmetrical in outline and corresponded in size to a pregnancy of fourteen to sixteen weeks. On vaginal examination the abdominal swelling could not be separated from the uterus, the cervix was soft and congested, and protruding from the external os was a vascular polyp, which bled freely on examination.

The diagnosis made at this time was a pregnancy of longer duration than the period of amenorrhœa would suggest, with the possibility of pseudo-menstruation having been caused by the vascular polyp. The Aschheim-Zondex test was positive.

24/10/37.—The cervical polyp was removed with the thermo-cautery, after which there was no further hæmorrhage.

8/1/38.—The patient was now seen for acute abdominal symptoms. She had complained of pain in the left *iliac fossa* since 4/1/38, which had become worse on 5/1/38, and was localised to the epigastrium and right side. She had vomited on 7/1/38.

Condition on examination.—The patient looked seriously ill, with furred tongue, pulse 120, and temperature 101°F., and complained of general abdominal tenderness. The uterus appeared to be about 28/30-weeks size, i.e., ten weeks larger than it should be if the last period was on 29/8/37, and four to six weeks larger than the size calculated on 22/10/37.

There was marked tenderness with some rigidity all over the abdomen, but both tenderness and rigidity were most marked in the region of the right hypochondrium, and in this area the uterine wall felt distinctly harder than elsewhere.

The patient stated that she had felt movements about a week previously, but no fœtal heart could be heard.

DIFFERENTIAL DIAGNOSIS.

Red degeneration of a fibroid.—The association of the gradually increasing pain, rise of pulse and temperature with a more or less localised area of tenderness and firmness of the uterus, was in favour of this diagnosis.

The presence of a fibroid would also explain the disproportion between the size of the uterus and the period of amenorrhœa which was noted on both occasions.

Acute appendicitis.—The fact that the pain had started in the left side, that the patient had been ill for four days without being in a more serious condition, and the relative lack of acute tenderness in the right iliac fossa or right kidney region was against this diagnosis.

Rapidly growing hyatid mole.—On the only occasion on which I had seen this condition with the uterus of comparable size, the patient was more seriously ill, and her main complaint was excruciating pain in her back.

I hoped to differentiate this condition by demonstrating fœtal parts by X-ray, but it was only after a careful search of the plate that the outline of a fœtal skull could be seen. The difficulty encountered was due to the fact that we expected to find a much larger fœtus than was actually present (see X-ray).

Twisted ovarian cyst.—The gradual onset of the pain, and marked elevation of pulse and temperature were against this diagnosis, and a cyst of this size would probably have been felt on the examination made on 22/10/37.

Acute pyelitis.—The onset of the pain in the left side, the lack of tenderness in both kidney regions, and the fact that a cathether sample of urine cultured on 5/1/38 showed no pus or organisms, almost ruled out this diagnosis.

Acute cholecystitis.—This is an occasional complication of pregnancy, but is more likely to occur in the puerperium. The history and findings on examination were against the diagnosis.

The provisional diagnosis before the operation was red degeneration of a fibroid, and was based largely on the X-ray picture and the clinical findings.

Treatment.

Most authorities advise that the treatment of red degeneration of a fibroid complicating pregnancy should be conservative. Shaw, for example, states: "Operative treatment is contra-indicated, for the symptoms subside with rest in bed, and further complications, such as infection, are most unknown."

In spite of this well-recognised fact, operative treatment was selected for two reasons—(a) the increasing severity of the symptoms, and (b) the size of the tumour as shown by X-ray.

When the patient was anæsthetised and the abdomen relaxed, the size and position of the tumour was well outlined, and it occupied most of the upper abdomen above the umbilicus, the uterus being below the umbilicus.

On abdominal section the tumour proved to be a fibroid about the size of a sixteen-weeks pregnancy, attached to the fundus and posterior walls of the uterus, which was about twenty-weeks size.

The tumour was excised from the uterine wall, the scar peritonised, and the appendix, which contained numerous copraliths, was also removed.

The patient made an uninterrupted recovery without a miscarriage occurring.

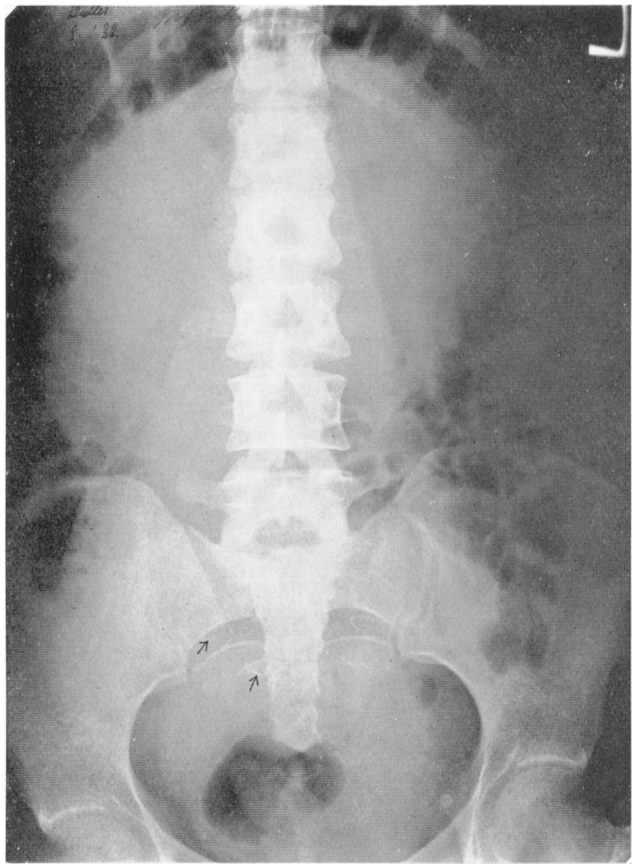

Fig. 1.
X-ray before operation, showing dense shadow of tumour. Arrows denote position of fœtal skull.

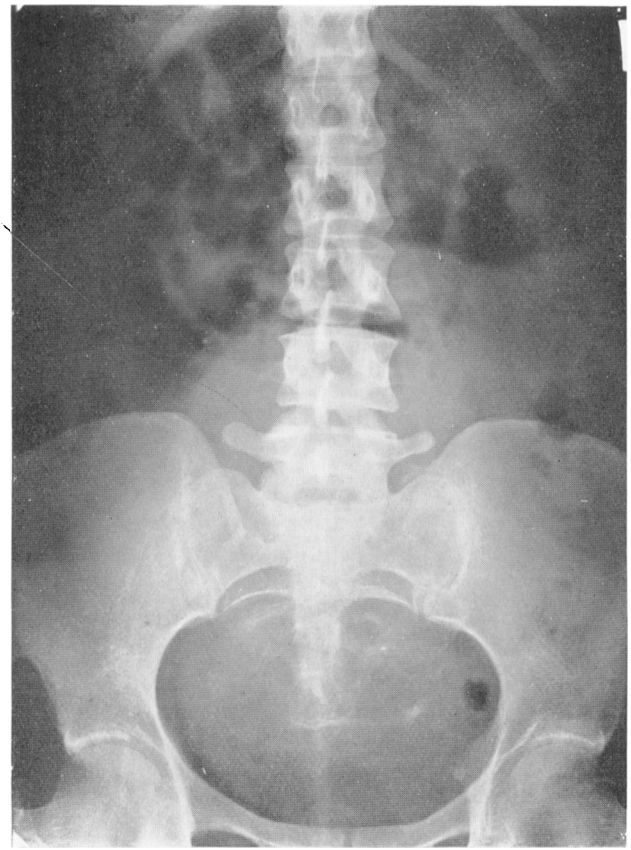

Fig. 2.
X-ray three weeks after operation.

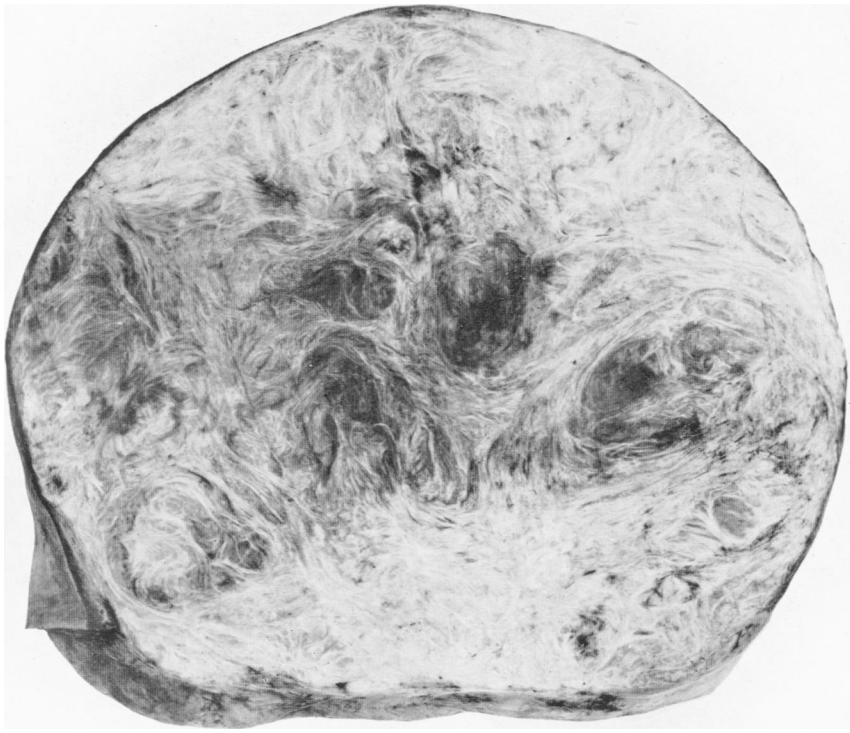

Fig. 3.
Photograph of tumour.